1. Introduction

1.1 Public Health Impact of Tobacco-use

Despite widespread knowledge of the harm caused by smoking, and concerted tobacco control efforts in the last decade, only modest success has been achieved in lowering the impact of tobacco morbidity and mortality. The World Health Organisation (WHO) estimated that currently, tobacco accounts for over 4 million deaths each year, a figure projected to rise to about 10 million deaths per year by 2030.[1] By that date, 70% of those deaths will occur in developing countries.[2]

Tobacco use is considered to be one of the chief preventable causes of death in the world.[3] The majority of adult smokers initiate the use of tobacco before the age of 18 during their adolescent years.[4] Recent trends show that the smoking prevalence rates among adolescents is rising;[4,5,6] and that the age of initiation is decreasing.[4,7,8] If these patterns continue, tobacco use will result in the death of 250 million children and young people alive today, many of them in developing countries.[9] Thus, adolescents and school-aged children should be a primary focus for intervention strategies. Carefully designed studies must provide an insight into the determinants of tobacco-using behaviour that place young people and school-aged children at risk. This data can then be used to develop scientifically sound interventions in order to increase adolescent tobacco health literacy, self-efficacy to prevent the initiation of tobacco-use or to increase their self-efficacy to quit. It could also provide the impetus for more effective and comprehensive tobacco control policies.

1.2 Tobacco-use in South Africa

Tobacco-use in South Africa (SA) is an ever-increasing health and economic problem. In 1990, 25 000 tobacco-related deaths were reported annually. The 1994 estimates of the economic cost of tobacco in terms of lost productivity due to premature deaths and hospitalisation exceeded R2,5 billion, while the direct cost of hospitalisation and outpatient treatment for smoking-related diseases in the public sector alone was approximately R1,5 billion per year.[10]

Reddy and associates[11], in a study in February 1995, reported that 34% of adult South Africans, or a total of seven million adults, smoke. This overall figure has increased by 1% per year since 1992. In particular, the smoking rate among the "Coloured"[a] population has increased by 12% when compared to the 1992 figure. The highest rate of tobacco-related deaths (one in five) compared to the national average of one in nine, occurred in the Western Cape.[12] The high smoking rates among this group were also reflected in the 100% increase in lung cancer mortality rates among "Coloured" men and the 300% increase among "Coloured" women during the 1970s and 1980s in the Western Cape.[13]

The October 1996 tobacco survey showed that the overall smoking prevalence amongst adults remained at 34%. However there had been an increase in the prevalence of smoking among adults in five provinces when compared to the prevalence rates of the February 1995 survey.[14] The smoking prevalence analysed by "race" and gender shows that the rate had increased for "Coloured", "Indian" and "White" males; and for "Black/African", "Indian" and "White" females. From February 1995 to October 1996, smoking prevalence in the 18 – 24 age group increased from 31% to 36%. The inference can be made that most of the members in this 18 – 24 age group most likely became regular smokers during their adolescent years.[15]

Meyer-Weitz et.al.[15] reported that the smoking prevalence rate for adults dropped to 25% in the 1998 survey. This corresponds with the smoking rate of 24% obtained from the South African Demographic and Health Survey (SADHS).[16] A possible explanation for the dramatic decrease in smoking prevalence from

a. During the Apartheid years, all South Africans were classified in accordance with the Population Registration Act of 1950 into "racial groups" viz. "Black/African", "Coloured", "White" or "Indian"; and the provision of services occurred along these "racially" segregated lines. The disproportionate provision of services to different "race groups" led to inequities. Information is still collected along these "racial" divisions in order to redress these inequities. In no way do the authors subscribe to this classification.

34% in 1996 to 24% in 1998 could be attributed to the introduction of health warnings on cigarette packages and all tobacco advertisements, together with the extensive media coverage that the impending tobacco control legislation received during that time period. In addition, the consistent increase in tobacco excise tax could also have impacted on the prevalence of smoking.

Despite all this information on adult smoking behaviour, there is a dearth of knowledge on the smoking behaviour of adolescents in South Africa. According to a literature review conducted on children and tobacco in Southern Africa,[17] it is difficult to obtain an overall impression of smoking prevalence due to lack of national representivity, differing sample sizes and methodologies as well as small geographical areas or "racial" groups being studied. The most recent national survey in SA, the SADHS, reported that the prevalence of smoking in the 15 – 19 year age group was ten percent.[16]

1.3 International Response to the Tobacco Epidemic

1.3.1 WHO Resolutions

Between 1970 and 1995, the WHO adopted 14 resolutions on the need for both national and international tobacco control policies. Four of the 14 resolutions underpin WHO's Tobacco Free Initiative (TFI), a United Nations Foundation (UNF) project. Member states were encouraged to implement comprehensive tobacco control strategies that contain the following:

- Measures to ensure that non-smokers receive effective protection, to which they are entitled, from involuntary exposure to tobacco smoke.
- Measures to promote abstention from the use of tobacco so as to protect children and young people from becoming addicted.
- The establishment of programmes of education and public information on tobacco and health issues, including smoking cessation programmes, with active involvement of the health professions and the media.
- Monitoring of trends in smoking and other forms of tobacco use, tobacco-related disease, and effectiveness of national smoking control action.

1.3.2 The United Nations Foundation Project

TFI/WHO received an award from the United Nations Foundation for International Partnerships (UNFIP), probably the largest single tobacco prevention grant, to initiate a joint project with the United Nations Children's Fund (UNICEF) titled "*Building alliances and taking action to create a generation of tobacco free children and youth*". The aim of the project is to collate the evidence, provide technical support, and create strategic alliances necessary to positively address the negative impact of tobacco and to encourage and support children and adolescents in leading healthy and active lives free of tobacco.

The project initially focused on a small group of developing countries, one per WHO Region, and draws upon the combined technical expertise and operational resources of a number of UN agencies – in particular WHO, UNICEF, and the World Bank. These agencies work together with the global scientific community, government and non-government agencies, institutions and systems within countries, the media, and with young people to show that together they can make a difference in this important public health issue.

The project is conceived as a dynamic and interactive process, whereby the activities and products of each phase will be used to inform and guide subsequent activities. The project consists of three distinct, but overlapping phases. The first phase focuses on harnessing the evidence for action viz.: synthesising the existing evidence from countries, some of which may participate in subsequent phases; undertaking new areas of research to support actions; and establishing the research-based evidence for developing future actions.

The second phase is the activating phase. Country Activating Groups (CAGs), with broad membership, will be formed in each of the participating countries as the coordinating and implementing mechanism to select and develop the components of a comprehensive country-based approach in addressing tobacco-use

among children and young people. Opportunities to promote the exchange of experiences and issues between countries and global activities will be developed and strengthened.

WHO and UNICEF technical staff from country offices, headquarters and regional offices, as well as other technical partners (e.g. The World Bank and the Center of Disease Control and Prevention, USA) play a key role in supporting the country-level work, in particular, through assistance with the identification, development and dissemination of programme support tools and resources; with young people in the project activities. In addition, WHO and UNICEF will ensure that tobacco is included as a component of existing programmes they operate within the country and any plans or agreements they develop with relevant governments.

The third phase involves taking the project to scale: producing and disseminating resources; strengthening regional capacity to sustain activities; integrating the products and results of the project into ongoing tobacco control work at the national, regional and global levels: transferring technology and experience between countries and regions; and strengthening cooperation and collaboration at all levels.

The overall coordination of this project is through TFI/WHO. The harnessing the evidence for action phase of the project will be coordinated by WHO, in collaboration with identified research experts from a range of developing countries. The activating phase will be coordinated by UNICEF country offices, with technical support and assistance from WHO.